STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
COMPROMISE AND RELEASE

ADJ12083731
Case Number 1

Case Number 2

Case Number 3

Case Number 4

Case Number 5

217-25-7160
SSN (Numbers Only)

Venue Choice is based upon: (Completion of this section is required)

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☒ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

OAK
Select 3 Letter Office Code For Place/Venue of Hearing (From Document Cover Sheet)

Employee(Completion of this section is required)

JONATHAN
First Name

MI

SHOCKLEY
Last Name

1000 SUTTER ST 123
Address/PO Box (Please leave blank spaces between numbers, names or words)

SAN FRANCISCO
City

CA
State

94109
Zip Code

Employer Information (Completion of this section is required)

☒ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

BIOTELEMETRY INC. DBA CARDIONET LLC
Employer Name (Please leave blank spaces between numbers, names or words)

1000 CEDAR HOLLOW ROAD
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

MALVERN
City

PA
State

19355
Zip Code

Applicant's Attorney or Authorized Representative:

☒ Law Firm/Attorney ☐ Non Attorney Representative

ZACHARY
First Name

KWELLER
Last Name

7912453
Law Firm Number

PACIFIC WORKERS OAKLAND
Law Firm Name

333 HEGENBERGER RD. STE. 504
Address/PO Box (Please leave blank spaces between numbers, names or words)

OAKLAND — City
CA — State
94621 — Zip Code

Defendant's Attorney or Authorized Representative:

☒ Law Firm/Attorney ☐ Non Attorney Representative

DOUGLAS
First Name

BURMAN
Last Name

11641868
Law Firm Number

COLANTONI COLLINS FOLSOM
Law Firm Name

444 SOUTH FLOWER STREET SUITE 2150
Address/PO Box (Please leave blank spaces between numbers, names or words)

LOS ANGELES — City
CA — State
90071 — Zip Code

Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)

CHUBB INDEMNITY INSURANCE COMPANY
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

PO BOX 42065
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

PHOENIX — City
AZ — State
85050 — Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

IT IS CLAIMED THAT:

1. The injured employee, born 09/27/1978 (DATE OF BIRTH: MM/DD/YYYY), alleges that while employed as a(n)

EKG TECH (OCCUPATION AT THE TIME OF INJURY), sustained injury arising out of and in the course of employment at the locations and during the dates listed below:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

☐ Specific Injury

ADJ12031731
Case Number 1

☒ Cumulative Injury

06/25/2018 (Start Date: MM/DD/YYYY) — 02/15/2019 (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 200 NECK Body Part 2: 315 ARM Body Part 3: 320 WRIST

Body Part 4: 330 HAND Other Body Parts: 340 FINGERS

The injury occurred at JOBSITE
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

SAN FRANCISCO (City), CA (State) 94105 (Zip Code).

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

Case Number 2 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____

(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ City , _____ State _____ Zip Code .

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

Case Number 3 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____

(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ City , _____ State _____ Zip Code .

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

Case Number 4 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____

(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ City , _____ State _____ Zip Code .

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

Case Number 5 ☐ Cumulative Injury _____ (Start Date: MM/DD/YYYY) _____ (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ City , _____ State _____ Zip Code .

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 369 is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY $ 956.64

TEMPORARY DISABILITY INDEMNITY PAID 58772.81 Weekly Rate $ 637.76

Period(s) Paid 03/01/2019 (Start Date: MM/DD/YYYY) 05/13/2022 (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID 17731.43 Weekly Rate $ 290.00

Period(s) Paid 03/12/2021 (Start Date: MM/DD/YYYY) End date ONGOING (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID $ 40478.60 Total Unpaid Medical Expense to be Paid By: DEF THROUGH OACR

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF

$ 52000
Settlement Amount

The following amounts are to be deducted from the settlement amount:

$ 17731.43 for permanent disability advances through 05/13/2022

$ _____ for temporary disability indemnity overpayment, if any.

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ 7800 requested as applicant's attorney's fee.

LEAVING A BALANCE OF $ 26468.57 , after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code section 5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

EDD

DEFENDANTS AGREE TO PAY AND EDD AGREES TO ACCEPT $1,125.00 IN FULL AND FINAL SATISFACTION OF LIEN ON REFERENCED CLAIM CONTAINED HEREIN.
INTEREST INCLUDED 30 DAYS. PAYMENT TO BE MADE TO
DISABILITY INSURANCE OFFICE
PO BOX 1857
OAKLAND CA 94604
TIN 94-2650401

9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (initial only those that apply). ONLY ISSUES INITIALED BY THE APPLICANT OR HIS/HER REPRESENTATIVE AND DEFENDANTS OR THEIR REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

Applicant	Defendant	
_____	DAB	earnings
_____	DAB	temporary disability
_____	_____	jurisdiction
_____	DAB	apportionment
_____	DAB	employment
_____	DAB	injury AOE/COE
_____	DAB	serious and willful misconduct
_____	DAB	discrimination (Labor Code §132a)
_____	_____	statute of limitations
_____	DAB	future medical treatment
_____	DAB	other MILEAGE; DEATH BENEFITS; PSI
_____	DAB	permanent disability _____
_____	DAB	self-procured medical treatment, except as provided in Paragraph 7
_____	_____	vocational rehabilitation benefits/supplemental job displacement benefits

COMMENTS:

*PARTIES HAVE REACHED AGREEMENT, BASED ON REPORTING OF QME DR. STOLLER AND COMPROMISE TO AVOID FUTURE HAZARDS OF LITIGATION, TO SETTLE APPLICANT'S CLAIM OF INJURY, IN ITS ENTIRETY FOR TOTAL SUM OF $52,000.00.
*PARTIES STIPULATE APPLICANT IS ENTITLED TO SDJB VOUCHER.

*DEFENDANTS WAIVE ANY RIGHT TO TTD OVERPAYMENTS ON FILE.

*APPLICANT ACKNOWLEDGES THE ADDRESS ABOVE IS TRUE AND CORRECT AND IS WHERE ALL SETTLEMENT PROCEEDS SHOULD BE DELIVERED.

*APPLICANT ATTESTS THAT HE IS NEITHER CURRENTLY RECEIVING MEDICARE / SSDI, NOR HAS ANY CURRENT EXPECTATION OF RECEIVING SAME WITHIN NEXT 30 MONTHS.
*THIS COMPROMISE AND RELEASE SETTLES ALL ASPECTS OF THIS CLAIM AND RESOLVES ALL ISSUES RAISED BY THE PLEADINGS, INCLUDING, BUT NOT LIMITED TO ANY AND ALL RETROACTIVE AND/OR ACCRUED BENEFITS SUCH AS TEMPORARY DISABILITY INDEMNITY OR PERMANENT DISABILITY INDEMNITY RETROACTIVE AND/OR ACCRUED BENEFITS, PENALTY AND/OR INTEREST CLAIMS, HOSPITAL, MEDICAL OR PRESCRIPTION EXPENSES, MILEAGE AND/OR PARKING, AND OUT OF POCKET EXPENSES PAID BY APPLICANT. ANY CLAIM FOR PENALTY OR INTEREST IS WAIVED IF PROCEEDS OF THIS SETTLEMENT ARE ISSUED WITHIN THIRTY (30) DAYS OF ORDER APPROVING COMPROMISE AND RELEASE ISSUANCE.

Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the workers' compensation administrative law judge may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING TO WHICH YOU BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.

THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

Witness the signature hereof this _____ day of _____, _____ at _____

Witness 1	(Date)	Applicant (Employee)	(Date)
Witness 2	(Date)	Attorney for Applicant	(Date)
Interpreter	(Date)	Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)

ACKNOWLEDGMENT

State of California
County of _____)

On _____ before me, _____
(insert name and title of the officer)

personally appeared _____,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ **(Seal)**